BHSF Form 90-L
Rev. 12/08
Prior Issues Obsolete

REQUEST FOR MEDICAL ELIGIBILITY DETERMINATION

I. RECIPIENT INFORMATION

A. Recipient's Name:		**SS #:**	**Medicaid #:**
B. Address (City, State, Zip Code, Parish):		**C. Responsible Party/Curator:**	
		Address (City, State, Zip Code, Parish):	
Telephone #:	**Race: Sex:**		
Medicare #:	**Date of Birth:**	**Relationship:**	**Telephone #:**

D. What are/were the living arrangements: ☐ **Own home** ☐ **Relative's home** ☐ **Other:**_____

E. What previous institutional care (including nursing facilities) has this person received?

Facility:	**Date:**	**Facility:**	**Date:**
Facility:	**Date:**	**Facility:**	**Date:**

F. What Home/Community-based services have been used/considered: ☐ **NOW** ☐ **CC** ☐ **Supports** ☐ **Other:**_____

G. Why were services not suitable?

H. Requesting Nursing Home placement: ☐ **Temporarily** ☐ **Permanently**

I. Applicant/Responsible Party Signature:_____ **Date:**_____

II. LEVEL OF CARE DETERMINATION

Institutional care is provided under classifications dependent upon the type and/or complexity of care and services rendered, as well as, the amount of time required to render the necessary care and services. The attending physician must designate the required level of care by selecting the appropriate level below. This requirement also applies to applicants requesting home or community-based waiver services to allow for a determination of the level of institutional care that would otherwise be required. Please select one of the following levels of care:

A. ☐ **Intermediate Care II (minimum care required) - Includes some aid in activities of daily living, diversionary activities, protection from hazards and/or a minimum.**

B. ☐ **Intermediate Care I (medium care required) - Includes need for nursing care to manage a plan of care and/or more assistance with extensive personal care, ambulation, and mobilization.**

C. ☐ **Skilled Care (maximum care required) - Indicate special level, if indicated:** ☐ **TDC** ☐ **ID** ☐ **NRTP (**☐ **Complex;** ☐ **Rehab) Includes professional nursing care and assessment on a daily basis due to a serious condition which is unstable or a rehabilitative therapeutic regime requiring professional staff.**

D. ☐ **ICF/DD - Requires active treatment of developmental disability under supervision of a qualified developmental disability professional.**

E. Is this person likely to need services in a medical facility (hospital, nursing facility, etc.) for at least thirty (30) consecutive days? ☐ **Yes** ☐ **No**

F. Are Home/Community Based Services adequate to meet the needs of this patient? ☐ **Yes** ☐ **No**

G. COMMENTS:

III. MEDICAL INFORMATION

Recipient's Name:

A. Diagnosis:_____

_____

B. Medications:(Specify dosage, frequency, and route) ALLERGIES_____

1. _____ **5.** _____ **9.** _____

2. _____ **6.** _____ **10.** _____

3. _____ **7.** _____ **11.** _____

4. _____ **8.** _____ **12.** _____

C. Recent Hospitalizations: (include psychiatric)_____

_____

D. Mental Status/Behavior: check Yes or No. If Yes, indicate frequency: 1 = seldom; 2 = frequent; 3 = always

☐Yes (1, 2, 3) ☐No 1. Oriented	☐Yes (1, 2, 3) ☐No 4. Comatose	☐Yes (1, 2, 3) ☐No 7. Hostile
☐Yes (1, 2, 3) ☐No 2. Forgetful	☐Yes (1, 2, 3) ☐No 5. Confused	☐Yes (1, 2, 3) ☐No 8. Combative
☐Yes (1, 2, 3) ☐No 3. Depressed	☐Yes (1, 2, 3) ☐No 6. Wanders	

E. Activities of Daily Living: (check appropriate box)

SELF	ASSIST	TOTAL			
☐	☐	☐	1. Eating	11. Verbal	16. Impaired vision _____
☐	☐	☐	2. Bathing	12. Non-verbal	☐ Glasses
☐	☐	☐	3. Personal	13. Bowel Incontinence	17. Impaired hearing_____
☐	☐	☐	4. Oral Hygiene	14. Bladder Incontinence	☐ Hearing Aid
☐	☐	☐	5. Ambulation	15. Urinary Catheter	18. Dentures _____

F. SPECIAL CARE/PROCEDURES: (check appropriate box: when appropriate give type, frequency, size, stage and site)

☐ **1. Ostomy care**_____ ☐ **7. MRSA**_____

☐ **2. Glucose Monitoring**_____ ☐ **8. Diet/Tube Feeding**_____

☐ **3. Restraints** _____ ☐ **9. Dialysis**_____

☐ **4. IV's**_____ ☐ **10. Respiratory** _____

☐ **5. Suctioning**_____ ☐ **11. Decubitus**_____

☐ **6. Specialized Rehab**_____ ☐ **12. Other**_____

G. PHYSICAL EXAMINATION: Height_____**Weight**_____**Pulse**_____**Resp**_____**Temp**_____**B/P**_____

Lab Results: HCT_____**HGB**_____**U/A**_____ **Radiology**_____

General_____ **Head and CNS**_____

Mouth and EENT_____ ___ **Chest**_____

Heart and Circulation_____ **Abdomen**_____

Genitalia_____ **Extremities**_____

Skin_____ **Other**_____

H. Physician's Name (Print)_____**PHONE**_____

Address:_____

Physician's Signature_____**Date**_____